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On Behalf Of:

Committee: House Committee On Behavioral Health and Health Care

Measure: HB3013

We live in a country where healthcare is a multibillion dollar industry and many in the industry are barely scraping by. Many small businesses are closing, patients are being neglected and hurt, and this is NOT sustainable. See the mass exodus of healthcare professionals over the last few years. Much of this has to do with the cost of prescription drugs which are ruled by PBMs. These PBMs have too much money and control and are on the way to becoming monopolies. They cost more than they produce, they harm people and companies, and they are great at pushing the blame elsewhere. They need to be regulated harder instead of being given free reign while other areas of healthcare are regulated to death.

PBMs are companies that manage prescription drug benefit programs for health plans. PBMs promote themselves as saving health plans and their covered members money, which helps them avoid regulation and so they keep their negotiations and the discounts or rebates they get from drug companies are very secretive.

PBMs commonly pocket funds that ought to be used to lower drug prices or lower copays. The common practice known as “spread-pricing” enables the PBMs to charge health plans higher prices than the PBM is paying to pharmacies, yielding additional unknown profits.
Reimbursement issues remain the biggest threat to community pharmacy viability, thus one of the biggest threats to patient access. Underwater reimbursement and non-transparent and outdated maximum allowable cost (MAC) lists, which reimbursements in most health plans and programs are based on, remain two of the biggest problems. Pharmacies are constantly reimbursed below drug acquisition cost and the cost to dispense regardless of the health plan or program because of PBM business practices.

Not only are pharmacies too often reimbursed below their cost at the time they fill a prescription, but they are also subject to retroactive claims reductions, or DIR fees. DIR fees are assessed weeks or even months after a prescription is filled. This practice further reduces reimbursements while providing little, if any, transparency, while straining pharmacy operations.
Because pharmacies have essentially no competitive bargaining power when “negotiating” a contract with PBMs they are usually forced to accept all contract terms-even those terms that are unfair and arbitrary. Considering three PBMs monopolize the marketplace and cover over 76% of insured lives, as a practical matter, a pharmacy cannot refuse a contract when potentially up to 50% of their patients would be covered by the contract.

These “take it or leave it” contracts are full of provisions that seem more anti-competitive in nature than for patient safety or program integrity. To compound matters, some PBMs require pharmacies to opt-out. That is, they will consider a pharmacy has agreed to the contract terms unless the pharmacy specifically opts out of the contract.
According to the 2008 National Community Pharmacy Association (NCPA) Annual Digest Report there were 248 independent pharmacies in Oregon. In 2022, there were only 90 independent pharmacies remaining. During that time, Mass Merchant and Supermarket pharmacies also declined, while only 43 Chain pharmacies opened, most of which were in larger market locations.

Thank you for considering these bills, which will improve the health of all Oregonians! You have the opportunity to fix the problem. Otherwise, patients across our great state will suffer.